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ANNUAL MEETING

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Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXX APRIL, 1960 No. 4

ANNUAL MEETING

The annual meeting this year is in San Francisco, October 29 to November 4. The California School Health Association is holding its annual meeting jointly with the American School Health Association.

Our headquarters will be the Hotel Whitcomb, but the A.P.H.A. informs us that all reservations must be through the Housing Bureau. An application blank is in this issue of the Journal. Make it out now requesting the Hotel Whitcomb.

SCHOOL HEALTH AND HEART DISEASE

BANICE FEINBERG, M.D.*

After examining a child, the school doctor sometimes writes on his health card: systolic murmur. How a school handles this information will determine whether the effect will be helpful or harmful. A child with a murmur may be placed in a special class; he may be barred from all play and exercise. A note from school may tell his mother that he has possible heart disease. If she is aware of the condition, she will be prepared for the news. On the other hand, if she has not been told of the murmur by her family physician, she may be furious with him, or she may be distraught until he has rechecked her child. The school may do nothing about the notation on the health card.

Consider this rather common example: Johnny's mother has received a stereotyped card from school stating "Your child has a heart murmur. Consult your family physician." Doctor Jones, the family doctor, has examined Johnny thoroughly, and he finds that Johnny has an insignificant, or so-called "functional" murmur. He does not have heart disease. Johnny has a normal heart. Dr. Jones has heard the murmur on several occasions, but feeling certain of its innocence, he thought it unnecessary to say anything. He thinks the school department should have consulted him before alarming the parents. If this murmur had not been evaluated, Johnny might have been labeled a "cardiac." He might have been deprived of normal activities, and because of the restrictions, he might have become too emotionally disturbed to keep up with his school work.

Although we have been discussing possibilities here, the problem is

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Chairman, Sub committee on School Health, American Heart Association.

real. How to treat the child who has a heart murmur is not only the concern of the family; it is both a school problem and a school responsibility. The school nurse, teacher, physical education instructor, guidance counselor, and of course, the pupil, too, must have an awareness and an understanding of the situation.

Let us now examine the facts. Then I wish to recommend some important considerations for a school program in relation to the detection, supervision and guidance of children with heart conditions.

Facts

Murmurs may be due to (1) congenital defects, (2) rheumatic fever and (3) no disease: murmurs with no apparent disease are referred to as insignificant, functional or innocent.

(1) Congenital defects. Usually, early in the child's life, parents learn that there is a congenital malformation of the heart. The so-called "blue baby" has a congenital defect in his circulatory system. Because of the defect, much of the blue blood from the right side of the heart mixes directly with the bright red blood from the left side of the heart, without first becoming pink as it would have, had it circulated properly through the oxygen-filled lungs. This is a serious and disabling defect. But thanks to modern heart surgery, many "blue babies" can now be completely cured. Others are helped to the extent that, with few or no restrictions, they can attend school. Many youngsters who are not "blue babies" but who do have other congenital defects, are not as seriously disabled. Their school routine must be adapted to the nature and severity of the heart condition; very often an almost normal school program can be followed.

(2) Rheumatic fever, which attacks most frequently those in the four-to-fifteen-years age group, is the most common cause of heart disease in childhood and adolescence. As a rule, parents know if there has been any heart involvement. Many rheumatic fever patients recover fully. In the past fifteen years, it has been my happy experience to find apparently normal hearts—without murmurs—in many children who have had rheumatic fever with significant murmurs two or three years earlier. Often, murmurs which persist have normal findings and are compatible with normal activity, including competitive sports.

(3) The third, and by far the largest group of heart murmurs, is often referred to as potential heart disease or possible heart disease. Most of the children in this group have normal hearts. Numerous medical studies indicate that 40 to 50% of normal children have, at one time or another, innocent or insignificant murmurs. I observed this frequency when I was a school physician many years ago. Their unimportance and insignificance were later borne out and confirmed when, as a medical naval officer in World War II, I examined recruits who had histories of heart murmurs. Many of the murmurs had been misinterpreted and these men, in their childhood, had been kept home from school and in bed for long periods, needlessly. Some have had serious emotional and psychological sequelae. With the above-mentioned facts in mind, we realize that detection, diagnosis and management are inseparable in importance.

Detection

There is no substitute for an adequate physical examination before

entering school. Because the family doctor knows the child, the child's history and the family make-up (very important factors in a valid evaluation of the whole child) his examination is preferable. When such examinations are not practical, children should be examined by the school physician, or by physicians at special clinics. A brief but pertinent report of, at least, the positive findings should be transmitted to the school department.

Yearly checkups by the family physician are wisest. Mandatory examinations, however, should be repeated, preferably at four-year intervals. A good schedule is: pre-school, 5th grade, 9th grade (especially with reference to high school sports), and before entering college. Experience indicates that more frequent school examinations are unproductive and too costly.

School examinations are obviously limited by time and inadequacy of equipment. They are of value in screening. Many findings require more thorough investigation. When economic or other factors make it impractical to be examined by a family physician, the youngster should be referred to hospital or special clinics, such as those sponsored and supported by local affiliates of the American Heart Association. School teachers and nurses should refer to the school physician, children who (1) appear more tired than usual, (2) begin to slip in their schoolwork, (3) are unusually prone to sore throats and severe colds, (4) are absent often or for long periods of time, and (5) have a disturbing change in behavior and personality.

School Health Program

The important task of handling school children with murmurs requires a good school health program. The teamwork of family, school personnel and physicians can establish and maintain beneficial health policies. The concept of the total child should never be lost. We must think of the heart as only a part of the whole child.

The frequent occurrence of heart murmurs points up the need for understanding the different types of murmurs. Whenever possible, adaptation of the school program should be made within regular classes; special classes are necessary only in rare cases. Transportation to and from school should be made available to those who need it. When based on medical recommendation, part-time attendance should be arranged. In many instances, classes may be scheduled so that there will be a minimum of stair climbing. The teacher's most important job is teaching, but she also has responsibility for supervising the young child with heart disease. Her handling of the situation will depend on knowledge, experience and insight. A sympathetic and understanding teacher treats the child as normally as possible; but she overlooks minor infractions and avoids tensions.

In the higher grades, good vocational guidance and general counseling can be very helpful. Every effort should be made to minimize any handicap that may exist and to help the youngster enjoy a happy school life. Of course, questions on precautions, limitations, etc., can be answered only by the physician, preferably by the family doctor.

Physical education instructors and athletic coaches can often provide adapted types of exercise and sports programs which can do much to build morale as well as provide needed exercise. Many "cardiac" students

can be on golf teams. They may be team managers, punters or field-goal specialists in football. In fact, some of our outstanding athletes have well-compensated heart conditions. The need for good supervision in high school athletics and a close rapport between coaches and physicians is obvious.

It is known that rheumatic fever and rheumatic heart disease follow streptococcus infections of the throat. The incidence of "strep" throat in school children can be very high, especially in winter. Such epidemics are usually followed by an increase in rheumatic fever cases. This does not imply that everyone who has a streptococcus throat infection gets rheumatic fever, nor does it mean that all rheumatic fever patients have rheumatic heart disease. Understanding on the part of the parents, teachers and nurses is important. With the cooperation of the school physician, the family physician and health authorities, streptococcus epidemics can be controlled, and many cases of rheumatic fever may be prevented.

In one of our large eastern cities, several years ago, there was a sudden increase in rheumatic fever cases. The local chapter of the American Heart Association and the local medical society cooperated with the school department, and the state and city health departments. The combined efforts of these agencies brought the epidemic under control. The area where most of the cases occurred was quickly pinpointed. Throat cultures were taken of all children in the schools in this area. Many more pupils than usual were found to be harboring streptococci in their throats.

The next step was to get permission from the parents, and then to administer small doses of penicillin—a very effective treatment for eradicating streptococci—to the children with positive cultures. Repeat cultures, taken several weeks later, were no longer positive.

The value of the team approach has been emphasized at every meeting of the American Heart Association's subcommittee on school health. The cooperation of the family doctor, school doctor, teacher, nurse, physical education instructor, guidance counselor, the family and the health department can provide opportunities for the interpretation and clarification of health issues so that there can be a better understanding of school health problems. This committee has also recommended that members of the school health team participate on panels, and that workshops be part of the educational program on school health. Good health policies can be carried out most effectively by the team approach.

Summary

Diseases of the heart differ in severity and significance. Many children have been needlessly labeled "cardiacs" with resultant psychological and emotional trauma to themselves and to their families. With proper supervision most of the children who have heart disease can lead fairly normal lives. A better understanding of the problem is needed at the grassroots level. The concept of the total child, not of the heart alone, is herein emphasized. An educational school health program carried out by the teamwork of family, physicians, school and health department personnel is recommended. The aim: good health policies for good health so that every child may profit from his school life as fully as possible.

REPORT OF THE STUDY COMMITTEE ON HEALTH EDUCATION IN SCHOOLS

W. K. Streit, Chairman

The Sub-Committee on In-Service Education in The School Health Program

ROY A. FOSTER, *Chairman*

In an attempt to keep their personnel up-to-date and to acquaint new members of their staff with their program, most school systems provide some type of in-service education. In the field of school health, the need for in-service education is most apparent. This committee has gathered together examples of in-service education programs that have been used successfully in working with school health personnel in various sections of the United States. No attempt was made to include all types of in-service programs, rather, only outstanding successful ones were considered. Each of the programs will be described in considerable detail with the hope that many school health people will be able to use one or more in their local situation.

An in-service program initiated and conducted by a local school system is maybe the most used today. One school system has been conducting continuous in-service activities for over ten years. The school staff is directly involved both in planning and in participating in the activities. Participation by members of the school staff is voluntary but high attendance and scholarship requirements are maintained. Each participant who successfully completed the in-service activity receives credit toward salary increases. Each group would meet twice a month during the school year and for one week after the close of school in June.

The leadership of the in-service activities was provided by supervisors and principals. In addition, resource people were invited to meet with the groups for one or more sessions. These resource people came from other city departments, civic organizations, voluntary health agencies and nearby universities and colleges.

Workshop methods were generally followed. Sometimes a critical problem was studied and then recommendations were made to the school administration. Curriculum planning and construction received considerable attention by these in-service groups. Dental Hygiene, Nutrition, Health Guidance and Counseling, Health of the Elementary School Child, Health and Safety in the Social Living Program, The Narcotics Problem, Secondary School Health Education, Sex Education, Family Life Education, Field Trips for Health Education, and First Aid courses are examples of the wide variety of topics offered in the in-service program of this school system.

Another school system centered their in-service activities around a School Health Education Evaluative Study. This study extended over a period of five and a half years. An outside expert was engaged to serve as Coordinator and Consultant for this intensive and extended evaluative study. Teachers, nurses, supervisors and administrators were involved from the schools. In addition, consultants from voluntary and official

health agencies, near-by universities and colleges, and also the State Department of Education was utilized as the need arose.

The participants were organized in groups or committees and studied such phases of school health education as: the meaning, purposes and functions of health education; identification of the health needs of children, youth and adults; reviewed research studies relative to changing behavior; developed criteria for evaluating a complete, functional school health program; appraised the status of school health education programs in selected schools; constructed instruments for evaluating health behavior; appraised progress of pupils in terms of changes in health knowledge, attitudes and practices; and appraised the evaluation procedures used in the study.

Given proper leadership, school health personnel in many communities can cooperate in evaluative studies which provide a two-fold result: First, an improved understanding of their school health program, and second, information for making their program more effective.

In-service education opportunities provided by state departments of education are very effective. In one state the Department of Health and the Department of Education jointly organized dental health in-service education programs throughout the state. These programs were organized to include all schools in a school system.

The dental health in-service education program was conducted by a team of public health personnel. This team consisted of a dentist or dental hygienist, a nutritionist, and two health educators. The time of such programs was generally immediately after school or, in some cases, school administrators would dismiss school one hour early. The program lasted for an hour and a half and was held in a centrally located school.

The program began with a snack. This was done for two purposes. It helped the teachers relax a little after teaching all day and it also provided an opportunity to demonstrate snack and party foods, low in refined sugars, which are suggested for good dental health. The snack was planned and prepared by the school's Home Economics Department. A State Board of Health nutritionist called on the local Home Economics Department several days before the meeting and helped them plan the snack.

As soon as all of the teachers had something to eat, the dentist spoke to them for about twenty minutes. His subject was, "The Dental Health Problems of School-Age Children." In his talk he emphasized the important role teachers play in the solution of this problem.

Following the general session, the teachers were divided into two groups. Teachers of grades one through six were placed in one group and teachers of grades seven through twelve in another group. This was done in order that specific information, materials, methods of teaching, and demonstrations could be directed to specific grades. Each group was led by a nutritionist and a health educator. They presented and discussed dental health education materials, conducted demonstrations, and showed different visual aids and explained how they could be used. Each teacher was given a packet of dental health materials which had been selected for the specific grade level at which they taught.

The success of this in-service education program was demonstrated by the keen interest of the teachers in the materials they received and the

audio-visual materials that were presented. School administrators reported an intensive use of the materials by the teachers in their classes.

In another state, a School and Community Health Workshop has been conducted most successfully for a number of years. This workshop was sponsored by the State Department of Education, the State Board of Health, the State University together with the cooperation of other state agencies, and voluntary and official health groups. Representatives from all of these groups made up a steering committee which met periodically throughout the year to plan the next school-community Health Workshop.

The workshop lasted two weeks and was held during the summer at the University. The participants could take the workshop either for college credit or for no credit. The participants consisted of both elementary and secondary teachers, nurses, school administrators, public health educators and others interested in school health. About 100 people participate each year. Many of the cooperating agencies provided scholarships to enable selected people to participate, and some local school districts paid the expenses of members of their staff.

The staff of the workshop was provided by the sponsoring and cooperating agencies. In addition, a leader in the field of school health from outside of the state was employed to serve as a general consultant during the workshop.

The workshop was organized around discussion groups. The topics for the discussion groups were selected by the steering committee prior to the opening of the workshop. As each participant registered, he would select the discussion group which was of most interest to him. In addition to the discussion group activity, speakers were brought in to speak and present reports pertaining to the various topics being discussed. These reports were general sessions which were attended by all of the participants. Periodically during the workshop, a representative from each discussion group would make a brief report at a general session. This procedure enabled all of the discussion groups to know what each of the others was doing.

The success of this type of in-service activity was shown by the enthusiasm of both the participants and those conducting the workshop. It provides all people who are involved either directly or indirectly in school health with an opportunity to get together and work out common problems and become familiar with the activities of others interested in the health of the school child.

In one state a voluntary health agency carried on an activity which proved to be very helpful to the teachers of that state. Each of the county representatives of the voluntary health agency gathered together samples of free and inexpensive materials that the teachers might use to supplement their textbooks in teaching health. These materials were evaluated by a group of teachers from the various grade levels and were arranged in groups according to grade level and health topic.

The county representatives for the voluntary health agencies then arranged with the school administrators to display these samples to the teachers. As each teacher entered the room where the display was set up she would receive an order blank and then as she saw materials that she could use, she would use the order blank to order it directly from the producer.

The enthusiasm of the teachers for this service was most remarkable. Apparently, many had little knowledge of the large number and variety of free and inexpensive materials that were available. By the use of this procedure, the teachers became familiar with supplementary materials and were able to conveniently order the ones they could use.

There are many other types of in-service activities that have proven to be successful but these are the ones that this committee feels were most successful from their own experience. It is hoped that from these activities, schools, health agencies and state departments will find suggestions for improving their in-service programs.

The Sub-Committee

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Dr. Franklin B. Haar, School of Health and Physical Education, University of Oregon, Eugene, Oregon.
Miss Florence Hellman, Kent State University, Kent, Ohio.
Mr. Malcolm McLelland, State Board of Health, Indianapolis, Indiana.
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Mr. Paul Schuster, Heart Association, Champaign, Illinois.
Miss Mary E. Spencer, Public Schools, Malden, Massachusetts.
Dr. Wesley M. Staton, Colorado State College, Greeley, Colorado.
Dr. Wilfred C. Sutton, University of California at Los Angeles, California.
Chairman: Dr. Roy A. Foster, Oregon State College, Corvallis, Oregon.

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REPORT OF THE STUDY COMMITTEE ON HEALTH EDUCATION IN SCHOOLS

W. K. Streit, Chairman

Sub-Committee on Guidelines for Curriculum Development in Elementary School Health Education

MARY B. RAPPAPORT, *Chairman*

The committee decided that basic questions for curriculum development are:

I. Why have a curriculum guide in health?
II. What constitutes a good one?
III. How do you make one?
IV. How do you use it?

Why Have a Curriculum Guide in Health?

The field of health is so vast and the teaching time so limited that careful planning and selection are imperative in developing a sound health curriculum. Without a health guide, instruction is apt to be "hit and miss." Such a written master plan is necessary for direction of all faculty members in order to have mutual understanding of:

1 Modern philosophy in health education
2 Basic principles underlining health instruction
3 Up-to-date accurate materials for teaching
4 Responsibilities of faculty staff members
5 Varied ways for enriching pupils' experiences in healthful living
6 Techniques for evaluating the effectiveness of the program

A guide is a source of help to the teacher in striving for common objectives. It is an aid for planning learning experiences that have continuity and sequential progression. It indicates ways of widening the horizon and avoiding the pitfalls of unnecessary repetition. It can be of great assistance to teachers in following accepted policies when confronted with controversial issues. It helps in delineating home, school and community responsibilities and in understanding how more effective cooperation may be achieved.

Teachers vary widely in their background, education and ability to teach health. They need help in deciding what is to be taught, how it can be taught best and what instructional materials to use. Content appropriate for the local situation must be decided upon and materials best suited to develop desirable concepts must be selected. To be effective, the curriculum should be developed in light of the needs and resources of the local community. A guide for each school system is essential since situations and problems vary greatly in different localities and no one guide can be effective for all communities.

What Constitutes a Good Health Guide?

A good guide in health is one which *teachers have helped to develop* since they have the major role in its use. By such participation, they are enabled (1) to expand their knowledge of the content, procedures and practices for teaching health; (2) to survey practices elsewhere; (3) to evaluate their own teaching activities in broader terms; (4) to explore and experiment with new ideas and (5) to examine, with expanded scope, new teaching materials and instructional aids. A good curriculum guide reflects what teachers want to accomplish and believe they can achieve.

A guide should have a clear statement of present-day concepts of health education. All forces should be considered that affect the health of pupils such as the influence of the home, the health services of the schools, the health resources in the community, the functions of health organizations outside the school, the health problems in the local situation.

A good guide is directional relative to what should be accomplished and suggestive of methods found to be effective. Leeway needs to be given for organization so that teachers can plan the instruction to meet the needs of their specific groups of pupils. Such a guide depicts how a well-balanced continuous program of health instruction can be planned and carried on, yet is so flexible that teachers may adapt and change their plans in terms of the health needs of the individuals and groups for whom they are responsible.

The scope of the school health program is indicated as well as the part which school health education has in the total program. Procedures are given to discover pupil health and safety problems. Sources to indicate basic characteristics and interests at the different stages of their development are important. These help teachers to identify and study health needs of pupils so that the instruction is functional and has impact in

changing attitudes and practices as well as developing understandings for personal health and safety and the protection of others.

Clear concise statements are essential for specific objectives. The purposes should be expressed in terms of desirable abilities, basic understandings, appreciations and beliefs that are applicable in the immediate community.

A good guide should indicate desirable areas to be covered at the various grade levels and point up opportunities to build on and relate to learnings at the previous grade levels. It should include suggested learning experiences and information regarding instructional ways of planning for and carrying on activities that will be meaningful, challenging, constructive and lead to maintenance and improvement of health practices. Suggestions should be included for teaching procedures and pupil activities. Lists of appropriate available materials for teachers and for pupils need to be carefully selected and compiled. Criteria for selection of materials, for evaluation of teaching methods, for judging pupil achievement in attaining objectives are essential components. Information about the community health organizations should be made available.

In other words, a good guide in health gives guidance in what to teach and how to make the teaching more effective. The overall coverage of resources should be thorough, yet allow for initiative and flexibility by the users.

How Do You Make a Guide?

The first step in making a guide is to find out what is being done in health education in the school system. Teachers, administrators—all available personnel should help in pooling information and learning what others have done. Criteria should be set up to determine what makes a good guide. Standards for evaluation of the present status of health and safety education should be compared with the accomplishment in attaining desirable objectives.

For example:

What evidence is available to indicate that health education has affected pupil health status?

Are the pupils becoming increasingly critical in recognizing their own health problems and those of the group and increasingly self-directing in their solution?

Is the school health education program appropriate for the varied developmental levels of the pupils?

Are the environmental opportunities of home, school and community being utilized for progress in achievement?

Is consideration being given to pupils' special interests and attitudes?

What means are teachers using to find out pupils' needs?

Is the health teaching based on development through healthful living as well as acquiring information essential for healthful living?

Are the parents cognizant of what the school is trying to do; do the teachers have understanding of the home situations?

What channels of communication are being used so that health standards at home and school are consistent and the parent and teachers are working together in seeking ways to attain these standards?

The development of a good guide takes time, leadership, participation by those who are to use it. It involves survey, research, study, evaluation.

A curriculum committee representing teachers, administrators, school health services, community health resources should be organized. Plans should be made for smaller working committees to represent the different grade levels as well as a cross section of the schools in the system.

A statement of philosophy consistent with the prevading philosophy of the total school curriculum should be developed. Plans should be made so that the committees have advice and resources available to help them in centering their activities on the fundamentals for constructive action such as:

(1) Developing general objectives
(2) Understanding the characteristics and needs of children at the varied developmental levels
(3) Organizing specific objectives in terms of practices, attitudes and understandings
(4) Planning the health experiences that children at the different grade levels need and should have
(5) Knowing the contributions of the school staff in helping to attain the goals such as administrator, teacher, health service personnel, psychological services, visiting teachers, school lunch personnel, custodians
(6) Realizing the responsibility of the teacher in planning and organizing instruction to meet health and safety needs of her pupils
(7) Organizing the placement of learning experiences to maintain pupil interest, to cope with their needs, to provide challenge and to be as effective as possible in achieving objectives.
(8) Ferreting out experiences which other teachers have found to be helpful for achievement of objectives
(9) Having resource materials, teaching aids and consultant services readily available
(10) Developing criteria for evaluation of outcomes

Example: Experience in curriculum development in Cincinnati

1. *The formation of Curriculum Committees*

When the primary curricular guide was developed committees were established for the areas taught in kindergarten through grade three of the schools. (Similar committees are also established for major revision of this guide.) Teachers were given an opportunity to volunteer for service upon these committees. (At least one-fourth of all eight hundred primary teachers participated upon the committees which made the latest revision of the guide. Their service extended over a two year period of study and work in bi-monthly meetings held outside of school hours. Many other teachers not upon the committees contributed to the work and thus the project was extensive and penetrating with respect to staff participation.) From the teachers volunteering for service, chairmen of the nine committees were selected. Each committee was also balanced in membership to secure representation at each grade level and to provide representation of difference in types of school communities. In general, the large number of teachers who volunteered took care of the balance in membership that was desired. A supervisor or principal was selected to act as adviser to each committee. An advisory committee composed of elementary principals was also established. The function of this committee was to find solutions to new administrative problems which needed to be met in furthering curriculum development. Finally, a coordinating committee composed of all chairmen and advisers was established to make decisions on issues which affected the course of the total project. This committee, among other things, heard progress reports and helped set time schedules.

2. *The Securing of Resources for the Curriculum Committee in Health and Safety*

A library of resource material was established and maintained by the adviser to the health committee. The library contained recent literature in the teaching of health, curricular guides in health secured from other urban school systems, pamphlets and brochures from local, state and national health agencies, books with factual information in such areas as nutrition or child development and research upon health and safety. As the committee found a need for additional resource material the library was expanded.

Consultants were also secured by the adviser when the need for their services arose. Among the consultants used most extensively by the committee were health educators from agencies in the community such as the

Safety Council, personnel in the Department of School Health Service such as physicians, the school psychiatrist and the social-psychiatric case worker and members of the Board of the Council of P.T.A.'s.

3. *Major Steps in the Work of the Curriculum Committee on Health and Safety*

A. *The initiation of the committee's work*

Consideration of the problems which the teachers faced in teaching health was the point of departure in the development of the new curricular guide. For the most part, these problems centered in the teachers' efforts to help children secure good health and safety habits. Through perusal of recent literature, the committee reassured itself in the belief that health instruction in primary grades should be directed toward making real and necessary changes in the behavior of children. The decision was reached to develop a curricular guide which would give the best possible assistance to teachers in providing instruction in health that would function in the lives of children.

B. *The study and decision-making step in the committee's work*

The committee spent approximately a year upon this phase of its work. Its efforts were directed toward the selection of instructional goals and determining how these goals would be most effectively attained. Extensive use was made of resource material and consultants during this time. Study and discussion were the major work procedures used. Reports of members of the committee and records of the committee's discussion were kept but no effort was made to produce copy for a curricular guide. The following curricular decisions were reached by the committee:

(1) that an effective program of health education in the schools would be concerned with the provision of a healthful, safe school environment, the planning and carrying on of a functional program of instruction and the securing of parental cooperation in reaching instructional goals.

(2) that these three facets of an effective program would be treated in the curricular guide.

(3) that instructional goals should be defined in terms of specific habits, attitudes and understandings that need to be developed; that the goals would be organized under the six basic health needs of all pupils; that instruction in kindergarten through grade three would be directed toward the attainment of these sets of goals.

(4) that learning experiences would be suggested for the attainment of goals and that these suggested learning experiences would be grade-placed to maintain pupil interest and provide variety and freshness in learning.

(5) that the responsibility of a teacher to plan and organize instruction around the health and safety needs of her pupils would be given major emphasis in the curricular guide and that the guide contain material which would assist the teacher to use this approach in teaching health.

C. *The production of the health and safety section of the curricular guide*

The committee decided upon the major topics to be developed. Sub-topics were then devised and members of the committee worked individually and upon sub-committees in developing these topics. Health in the school program was developed first and this section included what must be done to keep school environment healthful and safe. The sections on instruction in health and safety were developed next and finally the section on working with parents was written. The committee as a whole read and made suggestions on all copy produced. Drafts of the content were final only when approved by the committee.

After the committee submitted its material, some reorganization of it was made by the editor of the curricular guide. The adviser and chairman were consulted on the reorganization which involved taking certain parts of the material on Home-School Cooperation for use in the general, opening chapters of the curricular guide. This rearrangement of content helped to improve the health and safety sections.

How Do You Use It?

The teacher uses the guide to help in developing the plans which are made for teaching and to check the scope of health education. The learning experiences are suggestive and the teacher should feel free to use those applicable as well as to create and use new ones. The philosophy and objectives, however, should be considered as an obligation to the pupils, parents and community.

The administrator may use the guide with his committees as aids in evaluating the school health education program, as a means for coordinating health education with health services and other aspects of the curriculum.

Certainly it should be regarded and used as a guide, not as a prescription. It should serve as a road map, pointing out the main route while allowing the user to exercise judgment and choice along the way.

Its usefulness will be increased if the guide is accessible to all who have instructional responsibilities and feel that they had a part in its construction and an even greater part in its utilization and improvement.

Use of the guide should be a basis for continuous evaluation of the program in looking forward to its next revision.

The Sub Committee

Mr. P. C. Bechtel, State Department of Education, State Office Building, Columbus, Ohio.

Mr. Frank Jenne, Director of School Health, Dearborn, Michigan.

Miss Mary A. Thompson, Supervisor of Health Education, Board of Education, Prince George's County, Upper Marlboro, Maryland.

Dr. Jessie H. Haag, Department of Physical and Health Education, University of Texas, Austin, Texas.

Miss Helen Manley, Director of Health, Physical Education, Safety and Camping, University City Public Schools, University City, Missouri.

Mr. Edwin L. Kregenow, Supervisor of Health Education, Board of Education, Cleveland, Ohio.

Miss Olive Ewan, Supervisor of Primary Grades, Cincinnati Public Schools, Cincinnati 6, Ohio.

Chairman: Miss Mary B. Rappaport, Supv. in Health & Safety Education, Division of Health, Physical Education & Recreation, Dept. of Education, Albany, New York.

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REPORT OF THE STUDY COMMITTEE ON HEALTH EDUCATION IN SCHOOLS

W. K. Streit, Chairman

Sub-Committee on Methods and Procedures in Health Teaching in Secondary Schools*

ARTHUR L. HARNETT, *Chairman*

A Committee on Health Education in Elementary and Secondary Schools under the general chairmanship of W. K. Streit, reported on some present practices in secondary school health teaching.

Members of a Sub-committee representing nine states were asked to survey the health teaching in a number of secondary schools, asking the following two questions:

1. What successful methods and procedures are used in teaching health?
2. Why are these methods successful?

Members proceeded to obtain information in the following ways:

(1) A summary of 158 college students' opinions of their own health classes in high school (1950–56)
(2) A request for information from 51 school superintendents
(3) A survey of 25 high schools in one area
(4) Two summaries by teachers from their own personal experience in teaching
(5) A survey of the health teaching in one city school system

College Students' Opinions of their High School Health Classes

One hundred and fifty-eight college students preparing to be teachers analyzed the health courses they had taken in high school by indicating the strong points and weaknesses. Following is a summary of these opinions:

Strong points

1. The teacher was liked and respected. Knowledge of the subject, facts were used to back up teaching, good planning and preparation, interesting and enthusiastic teacher, well organized class period, fairness in dealing with pupils, good personality, voice qualities and personal appearance.
2. The teacher used a variety of class procedures. Good films, models, blackboard drawings, posters and other visual aids, class discussions, debates and panel discussions, up-to-date textbooks, good reference materials, informal classes, freedom of choice was given to pupils, a variety of topics, clear demonstrations, special projects for study.
3. The lessons meant something. Information was practical, the course was detailed and complete, the teacher used personal experiences, good class participation, items of interest were discussed, distinction was made between facts and opinions, current information was used as examples, teaching was put into actual practice, the subject was taught at the level of class understanding.

Weaknesses in Health Teaching

1. The classes were boring, uninteresting, and without much meaning. Repetition, formal lectures straight from the text, memorization required, texts were outdated, pupils did not take an active part, no opportunity for questions, health classes were used as a study period, too much detail on un-

*Presented at The Annual Meeting of The American School Health Association. Atlantic City. October, 1959.

important topics, discussions shifted from one topic to another, unimportant reports taken from newspapers, instruction too elementary, pupils considered health a "goof-off" course.

2. The teacher was poorly prepared and had no interest. The football coach discussed last week's game, poor quality tests, too much athletics and attentions paid to athletes in class, teacher showed favoritism in giving attention only to good students, physical education activities took the place of the health class, poor discipline in class, teacher always late for class.
3. The facilities and equipment were poor. Overcrowded classrooms, not enough books, dirty and unattractive rooms in the basement, no films or other visual aids, lack of material to read and study, auditorium and shop used as classrooms.

Methods and Procedures

1. Lecture-discussion is effective. This is helpful in explaining a difficult topic; an aid in introducing new materials not readily available as references for pupils; leading questions will bring out key points.
2. Class discussions also include recitation-discussion, panels, assigned reading with discussion and debates. Learning experiences would not be fully effective if there were no opportunity for discussion. Questions are encouraged. There is difficulty in getting pupils to do assigned reading.
3. Pupils are challenged. A self evaluation is made by each pupil as a guide and encouragement for class participation. "I try to stimulate questions and answers in a permissive 'health appreciation' atmosphere." Individual points-of-view are encouraged. Pupils are guided in an evaluation of their own health maintenance or correction.
4. Creative projects. Posters and table displays can be made effective when using paper mache, clay, wire, pipe cleaners, balloons. Some good topics are: mobilities on posture, puppet shows on food for teen-agers, digestive system, the eye, "a sweet tooth."
5. The Health Examinations. Screening tests are done by the pupils under teacher supervision, and preceding the health examination. Height-weight measurements, visual acuity, pulse rate, urinalysis (using specimens of urine brought to class after a demonstration of glucose and albumin tests by the teacher). Emphasis is on developing good doctor-examinee relationships and understanding rather than case-finding.
6. Pupil or teacher demonstrations. The teacher shows blood pressure measurement, use of a stethoscope, dissection of bovine heart or eye, hemoglobin comparison using a Talquist chart.
7. Student demonstrations are effective in Home Nursing and First Aid, particularly when pupils are encouraged to study and practice at home. A few examples: making a bed with a patient in it, bathing a patient in bed, artificial respiration, bandaging and splinting.
8. Special Projects. Usually undertaken by a few pupils, and including, for example:
   a. Preparation of charts and exhibits for local Science or Health Fairs, such as, "The Formation of Blood Clots," "The Normal vs. the Diabetic," "Blocks to Good Vision," "Keys to Health and Vitality."
   b. Participation in school projects such as the traffic safety program "Operation—Stay Alive." A school assembly program was done by pupils and a guest physician on the Blood Donor Program.
   c. Surveys and opinion polls are discussed and interpreted by means of graphs and posters. Accident hazard surveys, violations by pedestrians and drivers. Are women more considerate than men? What do sophomores worry about? What do seniors worry about?
   d. Test problems, such as "Breakfast Makes a Difference" (studying a measurable activity such as typing with and without breakfast); weight control and better eating habits.
9. Use of dramatics. Original skits can gain interest and often encourage the participation of a shy pupil in group activities. Recordings are sometimes put on tape either for replay or for the benefit of others.
   a. Many eating situations and problems
   b. Dating, etiquette and human relation situations
   c. Accident prevention
   d. Discipline of children and family relationships

10. Field Trips. Visits are arranged during or after school for class representatives. Some of the places or people the pupils have visited.
    a. Adoption agencies, police traffic court, cardiac clinic, marriage counselors, ministers, priests and rabbis, Tuberculosis Society, City Hall, state mental hospital, city waterworks, physicians, nurses and dentists, pure food and drug agent.
11. Other pupil activities
    a. Making use of "teachable moments" by considering a pertinent health problem of the moment. This willingness to depart from the planned program—if feasible—makes health a present and vital subject.
    b. Games and variety. Teams can be used for scoring on the basis of questions and answers. Fun and informative for review. The $64.00 question is posed for answer to be found from reading posted articles or analysis.
    c. "Buzz" system—an opportunity for partners to quiz each other orally on review questions for a test.
    d. Workbooks—only a moderate amount of interest shown by pupils.
    e. Library research. Pupils are assigned to the school library for a work period. Supplementary materials, pamphlets, books and magazine articles are made available.
12. Guest appearances of health agency personnel.
    a. County Tuberculosis and Health Association. X-ray films, model of tubercular lung, posters.
    b. Visiting Nurse Service. Techniques are demonstrated and services discussed.
    d. School dentist, using a high school age level approach.
    e. Highway patrolman, with slides and pictures to point up traffic accident causes and preventive measures.
    f. Insurance agent, to provide information on liability insurance, state laws.
13. Transfer of pertinent *personal* health problems seen in the school health center into *group* health counseling. The teacher can help pupils understand something of cause and effect relationships of illness.

The Sub Committee

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RESEARCH OF INTEREST

WESLEY M. STATON, ED. D.
Colorado State College
Chairman, Research Council, ASHA

Abstracts of selected research and reviews of research in school health education, health services and guidance, healthful school living, and health science . . .

Beal, V. A.: "Longitudinal Studies of Food Intake of Healthy Children." *Food and Nutrition News* 31: 1 (Mar.) 1960.

For the past 13 years, as one phase of a broad 30-year study of the growth and development of some 80 children, the Child Research Council of Denver has collected data on appetite and food intake and their relationship to growth rate and physical, social, and emotional development.

This progress report presents data derived from children during the first 10 years of life. In the first 18 months children increase their intake of calories, carbohydrate, fat, and protein. At 6 months for girls and 9 months for boys there is a dip in calcium intake, followed by a rise at about 2 and one half years. This drop results from sharply reduced milk intake and is accompanied by substantial decrease in milk protein between 6 months and 2 years. At the same time intake of protein from eggs, meat, fish, and plant sources rises.

Wide variations occur between children of the same age as well as within the pattern of an individual child over a period of time.

Pre-school children seem to present the major eating problem for mothers. Yet careful histories of food intake show that only milk and vegetables actually decrease during this period. Intake of eggs and fruits remain fairly stable, and meat, fats, starches, sugars, and desserts are consumed in increasing quantities.

Between 3 and 5 years most children show an increased interest in eating with consequent diminuition of feeding problems. From 5 to 10 children have relatively few food problems and parents are more concerned with manners than with intake. During these years there is a steady increase in intake and individual children are more consistent in their levels. Intake of boys continues to be higher than that of girls, with two exceptions: vitamin A and ascorbic acid.

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Editorial: "Smoking and Lung Cancer." *New England Journal of Medicine* 262: 417 (Feb. 25) 1960.

Referring to the massive array of statistical data linking smoking to lung cancer, this editorial takes to task the editors of the American Medical Association's *Journal* for "unwittingly" renewing the "controversy on the relation of smoking to lung cancer" in their issue of December 12, 1959.

Says the *New England Journal:* "there have been over two score . . . studies, *all* of which have . . . progressively implicated excessive cigarette smoking. No responsible observer can deny this association, and the evidence is now sufficiently strong to suggest a causative role." Taking dead aim at the tobacco industry, the report goes on to say that "in the face of this evidence the response of the tobacco manufacturers, and their

spokesmen, has been deplorable. They have distorted the facts beyond recognition. A bewildering array of paper tips has been added to their products, ostensibly to filter out harmful substances the very existence of which they deny."

A plea is made for wider dissemination of the facts among the medical profession and the lay public to prevent continued loss of life through the growing specter of lung cancer.

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Poe, N. M. and L. W. Irwin: "Functions of a School Nurse." *Research Quarterly* 30: 452 (Dec.) 1959.

Through use of the modified job analysis technique the researchers attempted to identify the specific tasks and responsibilities of school nurses.

Compilation and classification of the functions of school nurses were done in rank order for nurses employed by Boards of Education and for those employed by other organizations. Ranking high in both lists were follow-up, emergency, day-to-day, recording and reporting, inservice and professional, policy and planning, and community relations activities. Instructional services, medical examination, and healthful school living ranked 8th, 9th, and 10th for both groups.

Major conclusions: (1) school nurses carry out a wide variety of activities, (2) nurses working under Boards of Education report more different services than health department and other school nurses, (3) greatest single area of agreement between the two groups is that of follow-up function, (4) there is a growing need for more school nurses, and (5) school nurses evidence a need for broader educational background and experience.

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Rosenstock, I. M., Derryberry, M., and B. K. Carriger: "Why People Fail to Seek Poliomyelitis Vaccination." *Public Health Record* 74: 98 (Feb.) 1959.

The Public Health Service investigated the problems of (1) why people do not take advantage of the availability of polio vaccine, (2) what conditions influence people to seek the vaccine, and (3) what channels of communication provide information to different groups.

On the basis of evidence gleaned from this survey, the decision to seek poliomyelitis vaccination is determined by two factors: personal readiness and social-situational influences.

Personal readiness involves recognition of the fact that the individual and his family are susceptible to polio. Many persons, perhaps affected by repeatedly seeing pictures of a child on crutches and exposure to public information establishing age-priority groups, consider the infection as a children's disease. These people believe that poliomyelitis is milder in adults than in children. Of lesser significance in decision-making on vaccination are doubts regarding safety and effectiveness, procrastination, neglect, forgetfulness, and apathy.

Social pressures, especially those exerted by physicians and others who are important to the individual, sharply affect one's decision to have the Salk vaccine. There is considerably more interaction and communication among people who have had the vaccine than among those who have not. Convenience, as a situational factor, has a significant influence on

the decision to be vaccinated as does cost and acceptability of the facilities for vaccination.

Personal readiness and social-situational factors may be independently influential or they may interact. If a person is not ready to seek vaccination, strong social and situational forces will be necessary to bring about action. The authors indicate this to be the primary problem at present. Strong social supports will be necessary to bring about near-term behavior changes. Education requires time for optimal effectiveness.

Research in communications indicates that different groups are variably exposed to the several media, and that they derive different meanings from the same medium and content information. Further, people reached best through mass media generally are not those who most need the information. Possibly of highest significance: personal contact provides the most direct approach to vaccination speed-up.

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Stuart, H. C., Reed, R. B. and Associates: "Longitudinal Studies of Child Health and Development—Series II." Supplement to *Pediatrics* 24: 875 (Nov.) 1959.

This report describes the 27-year project, begun in 1930 by Dr. Harold C. Stuart, conducted at the Center for Research in Child Health and Development, Harvard School of Public Health. This research was based upon the cardinal concept that "variabilities in status by age result in the main from variabilities in progress and it is the latter which are related to health or have health significance." The fundamental objective of the research was to "secure, through periodic assessments, data relating to the progress of individual children from birth throughout the period of growth and development." One hundred thirty-four children—67 boys and 67 girls—were followed from birth to 18 years. They were examined at birth, 14 days, 3, 6, 9, and 12 months, and every 6 months to 10 years, and every year to 18 years.

Four facets of the study reported are: (1) patterns of skeletal development in the hand, (2) patterns of growth in height and weight, (3) caloric and protein intakes, and (4) patterns of illness experiences.

The study on skeletal development involved 66 boys and 67 girls. Roentgenograms were taken on these children at the time of every scheduled examination from 1 to 18 years of age. The chief purpose of this phase of the research was "to demonstrate the types and amounts of variability between children, as well as the consistencies manifest by individuals in the course of the skeletal maturation of the hand." Results showed that few children demonstrate marked irregularity in progress or change substantially in their rate of progress. The most common significant shift in rate of development occurs generally between childhood and adolescence.

Data on height and weight were collected on 134 children at semi-annual examinations in early childhood and annually thereafter. Measurements were in terms of centimeters for height and kilograms for weight. A crude classification of three 6-year intervals was followed: under 6 years, from 6 to 12, and from 12 to 18. Findings indicated that rate of growth before 6 is related to, though not precisely predictive of, size at maturity and beginning of adolescent growth spurt. Tables are presented showing means and standard deviations of height and weight according to age and

sex, frequency of occurrence of individual longitudinal patterns of growth, and individual patterns of boys and girls with slow, moderate, and rapid growth to 6 years.

In studying the calorie and protein intakes of children, dietary histories were taken from 1 to 18, including the data on the food habits of mothers during the prenatal period. Wide variances with age and sex are evident in the tabular data. Comparison of findings with the National Research Council's Recommended Allowances (1958) demonstrates that, except for calorie intakes of girls, average values were higher than the Council's Allowances. Many children varied substantially from the average pattern in level and rate of change of intake from year to year. Researchers conclude that "a cross-sectional mean is of limited value for prescribing the intake of calories or protein for an individual child at any age."

The final paper in this series reports the illness experiences of 67 boys and 67 girls from birth to 18. Illnesses were distributed by age periods: infancy, preschool, school, early adolescence, late adolescence, and total childhood. Illnesses were classified according to type, number, severity, and duration. Categories used were (1) respiratory illnesses, (2) gastro-intestinal infections, (3) communicable diseases, (4) "other" illnesses, and (5) accidents and surgery. A score system was used to better assess the stress of illness on health and growth. The preschool period—ages 2 to 6—showed maximum illness scores and frequencies, followed by school, early adolescence, and late adolescence in that order.

Subsequent reports will present findings relating to the different types of illness in terms of age and sex associations.

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Wheatley, G. M. and S. A. Richardson: "Some Approaches to Research in Childhood Accidents." *Pediatrics* 25: 343 (Feb.) 1960.

The authors review some of the research in child accidents. Their stated purpose is to "characterize briefly the prevalent type of research on accidents and some of the actions that have stemmed from its findings."

As is reasonably well known, accidents represent the major cause of death and disability among children. Public Health Service data indicate that for each child under 15 killed by accident, 1100 children are injured severely enough to require treatment by a physician or to be disabled for at least one day. In the United States more than one-third of all deaths from 1 to 19 years are caused by accidents.

Current research aims primarily at delineating the number and kinds of accidents by age groups. Such research has been useful in accident prevention but it has failed to provide information on why some children are more susceptible to accidents than others.

Limited evidence indicates that accidents are not entirely the result of chance factors. In one study of 61 nursery-school children accident repeaters were judged to be: "above average in strength; (2) courageous rather than lacking in nerve; (3) emotionally excitable rather than calm; (4) impulsive rather than cautious; (5) rude rather than courteous; and (6) 'very masculine' rather than 'sissy.' Other data showed that, in general, socially rejected children have a higher incidence of accidental injury than do popular children. Still another survey indicated that children having frequent accidents appear to be overactive, restless, and impulsive. Beyond this, accident repeaters want to be older than their

age, lack security at home, do not retreat from dangerous situations, become more impulsive under stress, and come from homes where other family members show above-average accident frequency.

The authors conclude by recommending increased emphasis on research of an interdisciplinary nature aimed at identifying *which* children are likely to be injured or killed, as well as shedding more light on the influence of human and environmental characteristics.

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NEWS NOTES OF INTEREST

• Although one in every three ninth-graders fails to finish high school, only a small percentage of drop-outs leave for reasons of health according to the *NEA Research Bulletin*, February, 1960. The study points out that this percentage could be cut still further, it seems, with the help of community agencies in spotting illness and arranging for care.

• Nurses and teachers will be especially interested in an article appearing in *California's Health*, February 15, 1960 which describes the educational value of a hospital "field trip" for second grade children. Harriet Clough, a public health nurse, reports in detail on the experience of such a visitation, in which a group of school nurses were prompted to help children to learn what a friendly place a hospital can be.

• The findings of the 1960 White House Conference on Children and Youth will be published in July. Orders may be placed for Conference Proceedings with the Publications Division, White House Conference on Children and Youth, 330 Independence Ave., S. W., Washington 25, D. C. The volume, which will contain the findings, recommendations, and addresses, will sell for $2.50.

• College health personnel will find the article by Edward J. Dvorak entitled "Educating for Health Through College Health Services" practical and readable. Mr. Dvorak is a Health Educator on the staff of the University of Minnesota Health Service. The article appears in the December, 1959 issue of *Student Medicine*.

• According to the National Health Survey 240 million school days were lost due to the acute infectious illnesses during the year ending June, 1958. The figure includes only those illnesses which were brought to the attention of medical personnel.

• Reported in the January 31 issue of *The Washington Post* is the announcement by the Superintendent of Schools that the Washington, D. C. schools would discontinue the use of telecasts because "they do not fit in with the District's regular course of study; they disrupt the instructional program." It is believed that this is the first school system in the country to imply by their actions that children cannot learn as effectively through instructional television.

• The 1959 revised edition of A Guide to National Defense Education Act of 1958 is off the press. The cost is 25¢ from the U. S. Government Printing Office.

☆ HOW WE DO IT* ☆

Our Dental Puppet Show

The knowledge gained, during the school dentist's talk to my class on the causes of tooth decay, was expressed in an original puppet show, "Susan Forgets." It was amazing how one student suggested the idea, and with his committee created the character names, plot, and script for this production. The scenery committee, and the costume and puppet designers collaborated with the writers to establish desired background. After several rehearsals, including a tape recorded one, the school dentist, parents, principal, and other classes received a written invitation to enjoy our culminating activity.

We felt proud, as third graders, to help Susan teach our guests such good health habits as:

1. We brush our teeth after every meal whenever possible.
2. We rinse our mouth thoroughly when we are in situations that do not permit brushing after meals (such as after school lunch period).
3. We eat proper foods to build healthy strong teeth.
4. We visit our dentist at least twice a year.

We are happy too, to have several colorful 2″ x 2″ slides to remind us of this activity.

The Gary Schools have in print a "Dental Education Teachers' Guide for Grades K–6." This guide which presents suggestions to the teacher on how to integrate dental education with art, language arts, arithmetic, music, play, general science, etc., may be obtained (50 cents) by writing to Mr. Robert Antonacci, Supervisor of Health, Physical Education and Safety, Virginia Street and 10th Place, Gary.

Jennie B. Alsobrooks
Third grade teacher
D. H. Williams Elementary School
Gary, Indiana

How We Do It: A Self-Improvement Project

Upon entering the required semester of health education on the Senior level at Cleveland High School, Seattle, Washington, we were asked by Mrs. Edna Roake, our teacher, to select and carry out a self-improvement project. The project could deal with some particular point of any of the four phases of health: emotional, physical, mental and spiritual. We were required to read five references and to devise a means to chart ourselves. We met in groups with those working on the same topic. An evaluation of our semester's work on the self-improvement project had to be turned in at the close of the semester.

The self-improvement program can put the student on the road to confidence and mental well-being. The success of such a program depends on the enthusiasm with which the student delves in to decide her short-

*An every-other-month feature of The Journal of brief reports of projects from the field. Contributions are welcome and should be sent to Dr. Arthur B. Harnett, Pennsylvania State University, University Park, Pennsylvania.

comings and seeks to overcome them. The zeal for improvement cannot come from the teacher; only true desire for correction on the student's part can accomplish the purpose.

Group therapy is difficult to practice because of the variety of problems and personalities, but well-organized group therapy can be beneficial in certain areas of self-improvement. More group work than can be accomplished in one semester in a school of approximately 1200 is often desired by some students. Some students continue work on their projects and achieve their goals after the initial semester work. The most important achievement of the self-improvement program is to awaken a desire to improve oneself independent of anyone's prodding.

—Submitted by SHARON VICTOR,
LOUISE ARAKI, AND TINA DEMPSTER,
Students at Cleveland High School,
Seattle, Washington

A Dental Project

June Dundon, School Health Nurse at Belmont Central School, Belmont, New York, writes an interesting report of two of her pet projects as a school nurse. The pupils in kindergarten to grade four observe Dental Health Week each year. This year they put on a program for the fifth and sixth graders telling them in various entertaining ways in song and playlets about good ways of gaining dental health. They were assisted by the high school Future Nurses' Club who put on an original play for the elementary pupils.

Future Nurses Club

The Future Nurses' Club of Belmont, New York received the first Charter in New York State granted by the National League for Nursing Committee on Careers when they made Future Nurses Clubs a national project. The Belmont Club did a radio tape for their local station telling of their purpose and about receiving their Charter.

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• The American Dental Association held a conference devoted to the improvement of dental health education films at the Association headquarters in Chicago, February 15 and 16. An invitation was extended to fifteen persons representing the areas of health education, dentistry, dental hygiene, dental health education, audio visual aids, television, and motion picture production. Perry J. Sandell is Director of the Bureau of Dental Health Education for the Association.

• The American Hearing Society has produced a new film, "The Glass Wall," which portrays the dramatic effects of rehabilitating persons with hearing impairments. The film was produced with a grant from the Office of Vocational Rehabilitation. Color prints have been placed with the member agencies of the Society and it is available free of charge for loan. The film is cleared for television.

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January, 1960

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COMING EVENTS

April 24–28
American Association for Health, Physical Education and Recreation, 75th Anniversary Convention, Miami Beach, Florida.

May 1–7
National Youth Fitness Week.

June 26–July 1
National Education Association, Annual Convention, Los Angeles, California.

June 26–July 2
American Physical Therapy Association, Pittsburgh, Pennsylvania.

June 21–24
Teacher Education and Professional Standards Conference, NEA, San Diego State College, San Diego, California.

May 15–19
National Tuberculosis Association, Annual Meeting, Los Angeles, California.

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A LETTER TO THE EDITOR

DEAR EDITOR:

On my mind is the very excellent contribution in the December *Journal of School Health* by Dr. Ruth Anderson Lawrence on the Rochester evaluation study of periodic school health appraisals. It seems to me that so important and prodigious a work on school health services should not be filed away without comment. This kind of analysis indicates the thoroughness with which this problem has been approached. Also there can be no question about the huge job involved in such a study so that we are all indebted for such a contribution.

If we accept the conclusion: "periodic school medical examinations during the first four years or elementary school are of little value from a case finding standpoint," we should consider how this should influence school health policy. If we do not accept the conclusion, we have facts to face.

At any rate this calls for discussion of policies and clarification of issues. For example, the six questions raised by Dr. Lawrence on the first page of her report are pertinent and deserve discussion in the light of the data she presents. I can think of other questions concerning policies involving periodic school medical examinations and Dr. Lawrence's data but this letter is not to point out questions that I think should be discussed.

What I want to suggest is that we have a try at comments, interpretations and ways of meeting the problems raised by this study. Last year the editor of "Pediatrics" wrote an editorial to stimulate discussion on "Can The New Pediatrics Be Practiced." There were many responses and they were enlightening. Differences were expressed but without rancor. Dr. Lawrence's report involves facts and we can only benefit from careful consideration of these and their meaning. Would you like to invite such responses?

Yours sincerely,

HAROLD H. MITCHELL, M.D.
R.F.D. #2
Gaithersburg, Maryland

(The Editor of the *Journal* wishes to assure Dr. Mitchell and others that he thus invites responses to the many provocative professional articles which are and will be appearing in the *Journal*. D.O.)

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POSITIVE TUBERCULIN REACTIONS

A LETTER TO THE EDITOR:

We in Colorado have been meeting a new and interesting situation in tuberculin testing that apparently deserves wider mention. The articles by Dr. Durfee and Dr. Piszcek in the February issue of the *Journal* prompts us to remind all who do routine tuberculin testing that false positives can be common and may increase in this country. Therefore, we submit a brief summary of current information on swimming pool granuloma, caused by mycobacterium balnei, (an organism similar to the tubercle bacillus) which has been isolated and studied at the National Jewish

Hospital in Denver in cooperation with the State Health Department and private physicians. This is the first identification of the organism in the United States but over 260 cases have already been reported to the Colorado State Health Department and more undoubtedly exist in this and other states. Mycobacterium balnei was first isolated in Sweden a few years ago from skin lesions caught in swimming pools. It lives at a lower temperature than the mycobacterium of human tuberculosis so makes warty growths on the outside of the body, particularly at elbows, knees, or knuckles where small abrasions occur when swimming. These granulomatous lesions will regress and heal spontaneously but they sensitize the victim to tuberculin in about 6–8 weeks. Thus, the chief significance of the disease is its interference with tuberculin testing—a fact that deserves the attention of all in school health work.

By coincidence the State Health Department was alerted to this new disease by a sudden increase in positive tuberculin reactors among pupils in the county. Two years ago a change was noted in tuberculin reactor rates when the 10–19 year old age group of pupils were found to be 12%–20% positive instead of the 3%–4% shown previously. Soon dermatologists and family physicians were concerned at the number of young persons with the "high school crud." When biopsy and culture studies proved mycobacterium balnei was present in the lesions, the puzzle of the high tuberculin reactivity was solved. The majority of the granulomatous cases gave positive skin tuberculin reactions though they had been negative reactors in previous years. Then the large natural hot water swimming pool which offers public recreation in this area was later discovered to be heavily contaminated with mycobacterium balnei necessitating the pool's closure for $250,000 repair and remodeling.

Continued research will be done and may devise a way to separate the mycobacterium balnei infections from the true tuberculosis infections. Until then, there is good evidence that *a large percentage of these pupils with positive skin tuberculin reactions are not infected with tuberculosis.* This fact must be appreciated to insure accuracy in our school health programs. To the current query "Should tuberculin tests be continued when it is now known positive reactions are not entirely specific?," the answer is "YES." Both the Colorado State Department of Public Health and the State Department of Education recommend routine skin tuberculin tests, either Mantoux or Patch as preferred in local areas, and urge the testing be accompanied by adequate and accurate health instruction. But physicians and other school health personnel must be informed about this new disease which may interfere with tuberculin testing.

LELAND M. CORLISS, M.D.
MILDRED E. DOSTER, M.D.
Health Service Department,
Denver Public Schools

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• "School Mental Health," is a 11-page pamphlet describing the program of the National Institute of Mental Health. It may be obtained from the Superintendent of Documents, U. S. Government Printing Office for 10¢. The publication date is July. 1959.

ASHA-AMA JOINT SCHOOL HEALTH MEETING

The second Annual Pre-Convention School Health Forum, sponsored jointly by the American Medical Association and the American School Health Association, will be held on Sunday evening, June 12, 1960, in the Medallion Room of the Carilon Hotel in Miami Beach, Florida. This is the evening prior to the American Medical Association's Annual Meeting in Miami Beach and will be an unusual opportunity for continuing the relationships between the American School Health Association and the American Medical Association.

All physicians who are attending the Convention and have any interest in school health are urgently invited to be present, and special invitations are being sent to all American School Health Association Members and Fellows in the nine southeastern states who might care to be present. All who attend this meeting and wish to stay over to view the exhibits and attend some of the functions of the American Medical Association's Annual Meeting will be issued guest badges.

The program will consist of a symposium of outstanding representatives of the various disciplines in the school health program as well as a free discussion by those present on such problems as they may wish to bring up. The program will be under the general supervision of Donald A. Dukelow, M.D., who is an officer of the American School Health Association and a staff member of the American Medical Association.

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FIFTIETH ANNIVERSARY OF SCHOOL HEALTH SERVICE IN CLEVELAND PUBLIC SCHOOLS

Cleveland was one of the first cities in the United States to provide Health Service for school children through its Board of Education. This came about December 13, 1909 by a Resolution of the Board upon the recommendation of William H. Elson, then Superintendent of Schools, who firmly believed and so stated, "Medical Inspection in the schools, to be effective, must be under the control and supervision of the Board of Education."

Ten physicians and ten nurses were employed and started work in September 1910. Dr. H. S. Sherman was Directing Medical Supervisor and Miss Grace Sanford, R.N., was Supervising Nurse. The program was primarily devoted to control of communicable disease and environmental sanitation. Today, the staff is composed of over one hundred persons—physicians, dentists, public health school nurses, dental hygienists, an audiometer technician and psychiatric social workers, serving a school population of 130,000.

The program is comprehensive, encompassing the physical, mental, emotional and social health of the school child with emphasis on promotion of health through education. Health Service now is considered to be an integral part of the total school program—a strong factor in family and community health.

In celebration of this 50th anniversary celebrational banquet will be held and Cleveland extends a cordial invitation to any one who is interested to join them on May 11, 1960—at the Hotel Carter.

For further details contact Mrs. Patrick at the Cleveland Board of Education, Cleveland, Ohio.

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A leading book giving specific guidelines and basic principles for the health education curriculum, and suggestions both for content and administrative policies relating to health services and for the implementation of school health programs. Features of the present edition: amplified discussion of motivation; completely revised illustrations of lesson plans and curriculum guides; new techniques for health appraisals and screening; a modern perspective of school and community relationships as they bear on child health. Full bibliographies.

Due May 15

Science and Medicine of Exercise and Sports

Edited by WARREN R. JOHNSON,
University of Maryland

The first book of its kind, this is a symposium to which some 35 researchers—noted authorities in physiology, physical education, psychology, and medicine—have contributed chapters. Here is a statement of our present knowledge of the various aspects of the general field of exercise and sports. The book encourages research by indicating the limitations of our knowledge and the directions in which further research is needed. 87 figures.

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SAN FRANCISCO ANNUAL MEETING, OCTOBER 28-NOVEMBER 4

A Housing Bureau will be operated by the San Francisco Convention and Visitors Bureau for the Association. Since all requests for rooms are handled in **chronological order,** it is recommended that you send in your application as quickly as possible.

In making hotel reservations please use the blank below, indicating your first, second, and third choice of hotels listed. Because of the limited number of **Single Rooms Available,** you will have a better choice of securing accommodations in the hotel you prefer if your request calls for rooms to be occupied by two or more persons. Rates quoted are for the room, and in case of double occupancy, the rate will be shared.

No Minimum Rates, or any specific rate within the full price range quoted, can be guaranteed when your reservation is confirmed. Hotels make every effort to give you the requested rate. However, this is governed by prior check-outs and availability of such rooms on the date of your arrival.

All Requests Should Be Accompanied by a Deposit Check for $10 per room made out to the **APHA Housing Bureau.** Hotels cancel unclaimed reservations by 4:00 p.m. Therefore, a deposit is requested to insure that your reservations will be held on your arrival date—whatever the hour. Your deposit will be credited to your account. **Please Do Not Send Cash.**

Cancellations: Cancellations must be received 15 days prior to the meeting for refunds of your deposit to be made by the hotel.

Late Requests: Applications Received Later Than October 16 (15 days prior to the opening date of the convention) **will be returned.** In such cases please select your own hotels and write to them direct.

All reservations must clear through the Housing Bureau. All requests must give definite date and approximate hour of arrival and names and addresses of all persons who will occupy rooms requested.

ALL RESERVATIONS WILL BE CONFIRMED IF REQUEST IS RECEIVED NOT LATER THAN OCTOBER 16.

MAIL TO

APHA HOUSING BUREAU
Room 300, 61 Grove Street
San Francisco 2, California

(**Note:** Single rooms are very scarce. please arrange to share a twin-bedroom with another.)

PLEASE MAKE RESERVATIONS NOTED BELOW:

First Choice Hotel.....

Second Choice Hotel.....

Third Choice Hotel.....

Single Room.....

Double Bedroom.....

Twin Bedroom.....

Parlor, Bedroom Suite.....

Arrival.....at.....A.M.....P.M. Departure.....

NAMES OF ALL OCCUPANTS:
(Please bracket those sharing a room)

ADDRESSES:

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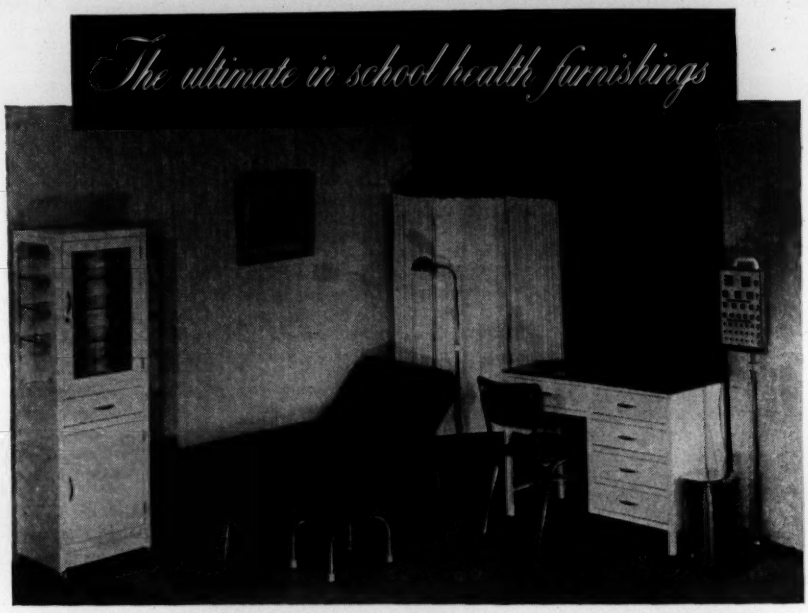
Check for $.....payable to **APHA Housing Bureau** is enclosed. Please enclose a self-addressed stamped envelope.

MAIL CONFIRMATION TO: (Signed).....
(Please print or type)

Address.....

City.....Zone.....State.....



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